Division of Disability and Rehabilitative Services
Bureau of Quality Improvement Services
Mortality Review Committee (MRC)

History and Purpose

The Mortality Review Committee (MRC) is an integral part of the Quality Improvement Committee process for the Bureau of Quality Improvement Services (BQIS). The information gained by the MRC is used to identify trends; direct training needs and develop recommendations that are forwarded to the Quality Improvement Executive Council (QIEC), which is made up of the Division of Disability and Rehabilitative Services (DDRS) Director and the DDRS Bureau Directors. The MRC is chaired by a staff member of the Bureau of Quality Improvement Services. The Director of the Bureau of Quality Improvement Services reviews any recommendations made by the MRC and has the final approval on all recommendations. Members of the MRC include a community physician, a Registered Nurse representing the Office and Medicaid Policy and Planning, and a Registered Nurse representing the Bureau of Aging and In-home Services (BAIHS). The DD Waiver Ombudsman and an Adult Protective Services Representative also represent the BAIHS. Representatives from the Bureau of Developmental Disabilities Services, Advocates, and Indiana Department of Health round out the MRC membership.

The MRC came into existence February 2, 2000. Originally, it was started by the Division of Disability, Aging and Rehabilitative Services Quality of Life Unit (QLU). In January 2001 the QLU became the Bureau of Quality Improvement Services (BQIS) which continues the MRC today. Since its inception 658 deaths have been reported to the MRC. 621 of those cases were reviewed by the MRC (37 of the reported cases were not reviewed because the individuals were not receiving services through the Bureau of Developmental Disabilities Services (BDDS)). 381 of these cases were reviewed and closed with no recommendations being made. The MRC did make recommendations on 277 of the cases reviewed. The average processing time for a case, from the report of death to completion of the review, is approximately 4 months.

The MRC meets on a monthly basis to review information relative to the death of persons receiving developmental disability services provided under the auspices of the Division of Disability and Rehabilitative Services (DDRS). The specific DDRS service types for which case file information is reviewed are the State Developmental Centers; large and small private ICF/MR facilities; community based residential services; or day/vocational habilitation services. The MRC also reviews case files of individuals who received any of the service types listed above and either died in a hospital setting or within 90 days of moving to a nursing home.

The MRC endeavors to collect as much information as possible for the cases it reviews. Some of the different types of information requested include Notification of Individual Death form, the incident report, medical records, the death certificate, chronological notations of all service providers for a period of thirty (30) days prior to the end of services being provided to the individual, and when applicable, hospital discharge documents, the coroner's report and the autopsy report. The MRC may request additional information based on questions that are brought forth during the Sub-Committee's

review. The MRC's main objective is to ensure that the care and services received were appropriate and meet community standards of practice. The more thorough the information the more easily this can be done

The MRC is aware they can not change the circumstances that led to that person's death; however, the MRC strives to use the information submitted for review to identify trends, direct training needs, recommend development and/or modification of provider policies, or to modify state policies to address systemic issues that are seen during the review. An important outgrowth of this process is recognition of best practices and recommendations to implement those as systemic changes. As a result of systemic recommendations being sent for review and action to the Quality Improvement Executive Council, many of the recommendations made by the MRC have been incorporated in the Provider Standards for Waiver settings. These include requiring that all staff is trained in First Aide/CPR, side effects for medications, and the specific items being reviewed in the development of Individualized Support Plans, such as dining plans and medical needs. The MRC has also made specific recommendations to BQIS that provider agencies review or create policies to better equip the agency's staff in handling various situations, and BQIS has assured that the provider has made such changes. The MRC has also referred situations to other state entities that may need to further review the situations, such as registering a complaint to the Indiana State Department of Health regarding the treatment an individual received at a hospital emergency room. By reviewing the information from each death, it is the MRC's intention to provide feedback that will help initiate the changes necessary to ensure the provision of services received is safer for all individuals.

The MRC Process:

When an individual receiving services through BDDS dies, the individual who is aware of the death must make a phone call to BDDS to initially report the information within 24 hours. In addition they must file an incident report through the incident reporting process. Per the BDDS Incident Reporting policy, a death also requires that the incident report is faxed to Adult Protective Services or Child Protective Services.

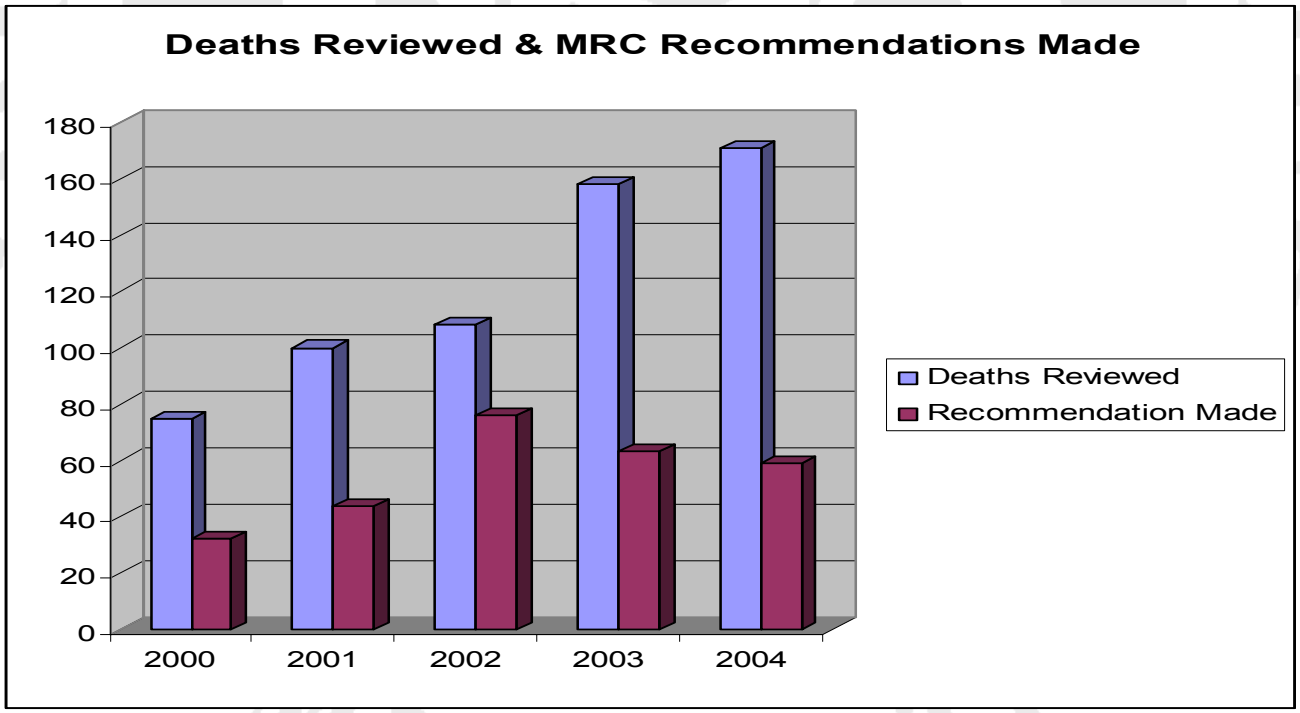
The provider will receive a letter from Bureau of Quality Improvement Services (BQIS) to complete the Notification of Individual Death Form (a copy of the form is provided). This packet of information is due within 15 days of the date of the BQIS letter. (This is sent the day the report arrives at BDDS.)

The reporting provider is asked to complete the packet with input from other providers, family and case managers. Because the Death Certificate is public record and available from the County Health Department, BQIS asks that the providers obtain that document and include it in the packet. Hospital discharge documents, coroner's reports and autopsy reports require a release of information signed by the next of kin for the deceased, so these documents are not always available for MRC review.

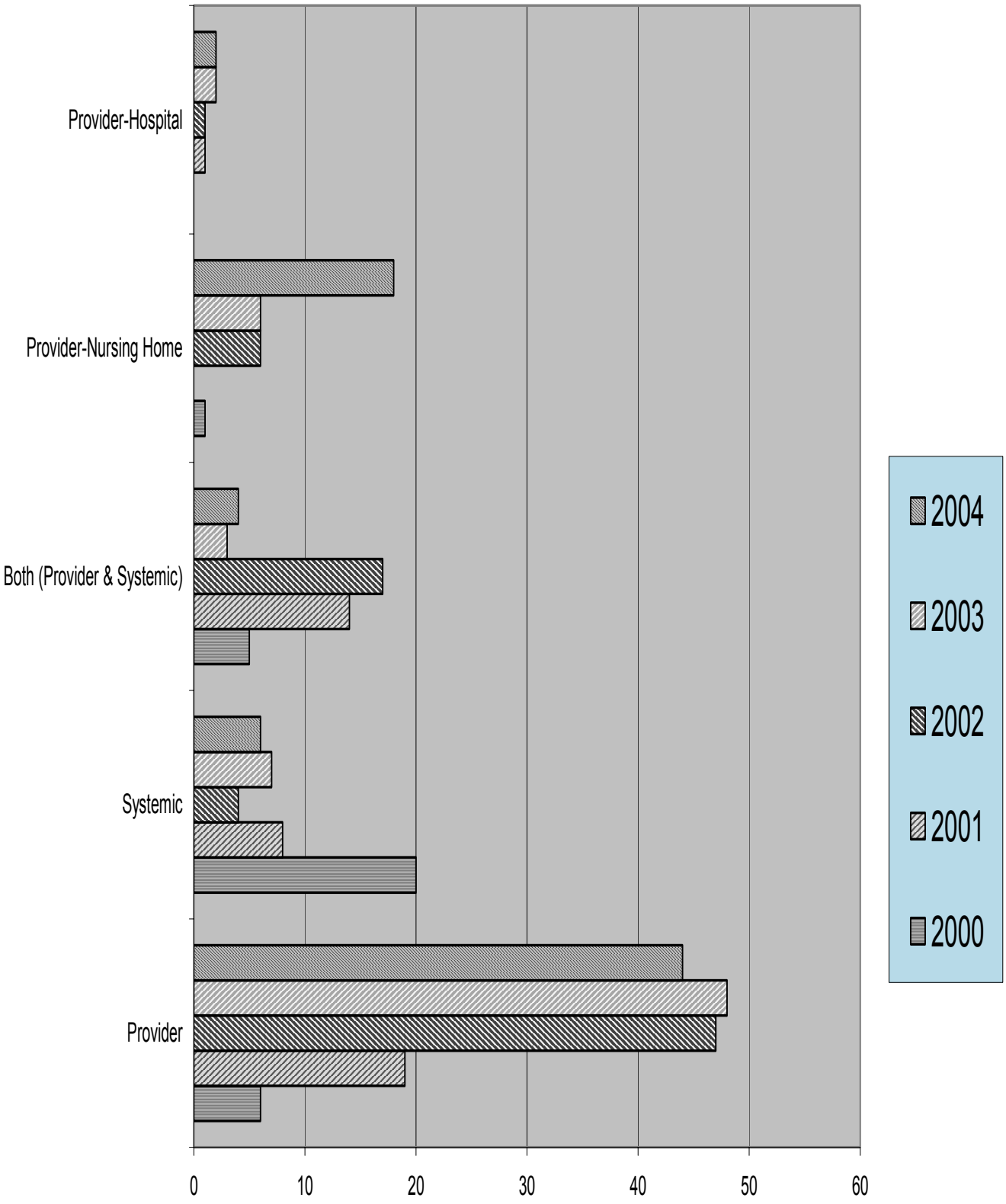
Upon receipt of the packet of information, staff from BQIS will review the packet for completeness and may request additional information to clarify the report for presentation to the MRC. These packets are presented to the MRC for review. In the past, packets were reviewed by each Committee member and discussed at the monthly meetings.

In order to streamline this process and enable the Committee to review more cases, Sub-Committees were established. These Sub-Committees meet prior to the monthly meetings, discuss the cases and make recommendations to present to the full Committee each month. The Sub-Committee may request additional information based on questions that are brought forth in their discussion. The provider will be given a target date to provide the additional information. Once the Sub-Committee has reached a consensus about the case, the case will be reviewed by the entire Committee who has received the Sub-Committee's recommendations. The full Committee then discusses the case and finalizes the recommended action to be taken in each case. The Committee can close the case with no recommendations or approve recommendations made by the Sub-Committee to refer the case to the appropriate agency for corrective action. In cases where no recommendations have been made, the provider is informed that the review has been completed and that no recommendations have been made. For cases referred to BQIS, the provider is notified of the review completion by BQIS. The providers in those cases referred to other agencies, such as the Indiana State Department of Health, receive a letter from the MRC stating the review has been completed and no recommendations were made. This is done per ISDH's request to enable them to perform an unbiased investigation of the information involved.

Deaths Reviewed & MRC Recommendations

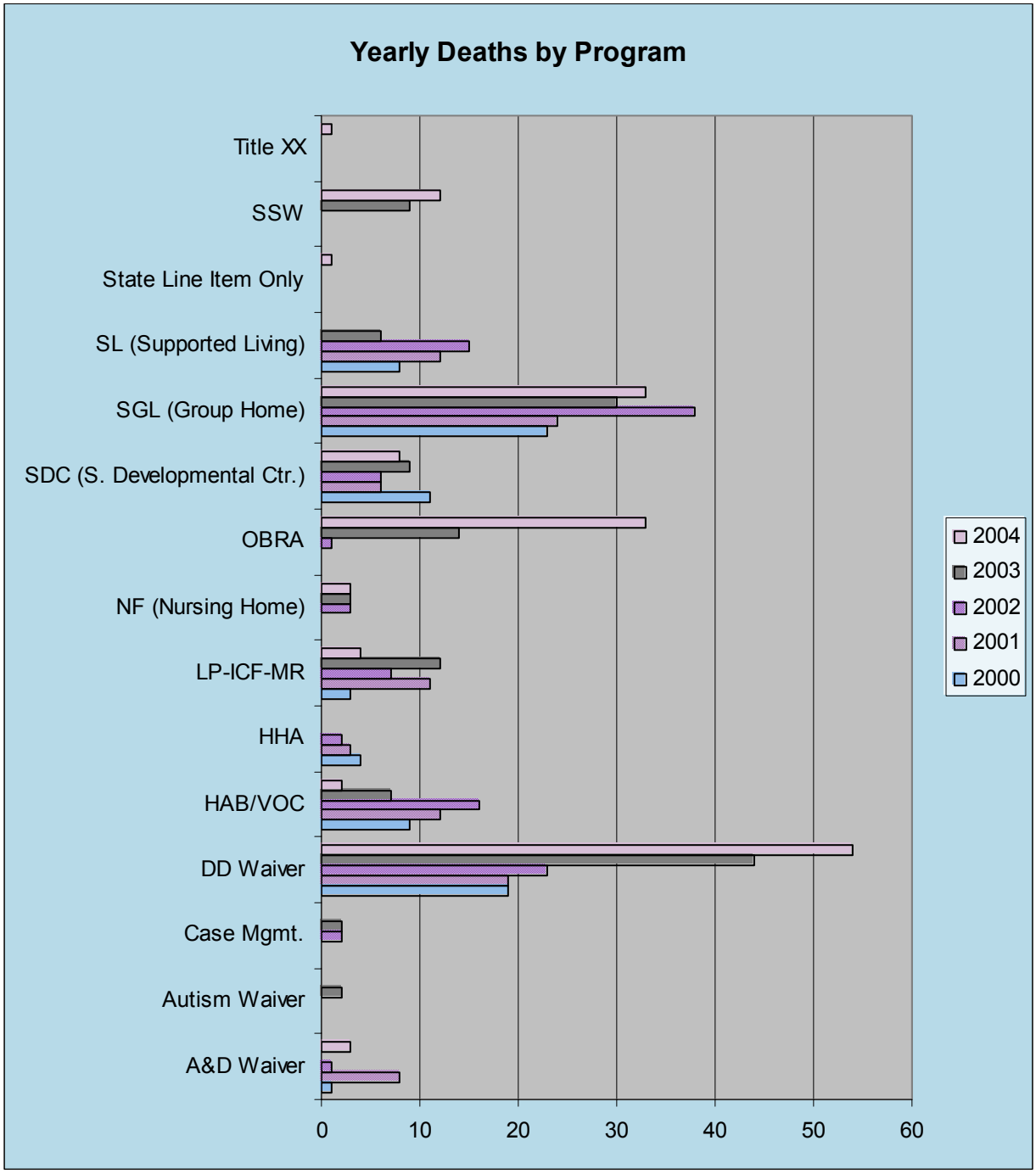


Recommendation Categories



Deaths MRC Reviewed by Program

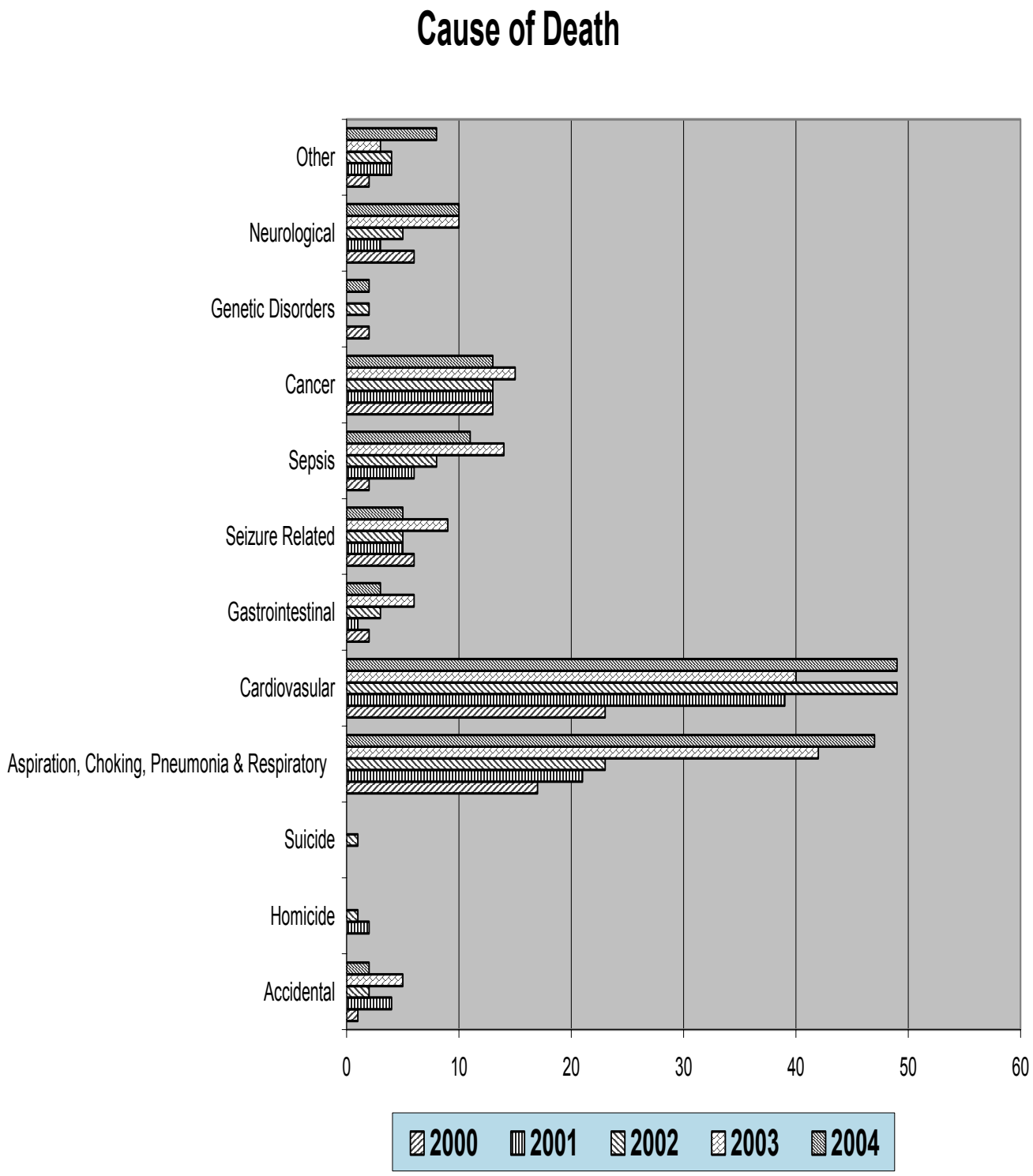
The Bureau of Developmental Disabilities Services offers services through various programs. Deaths reviewed by the MRC are depicted below by the program providing services to the individual.



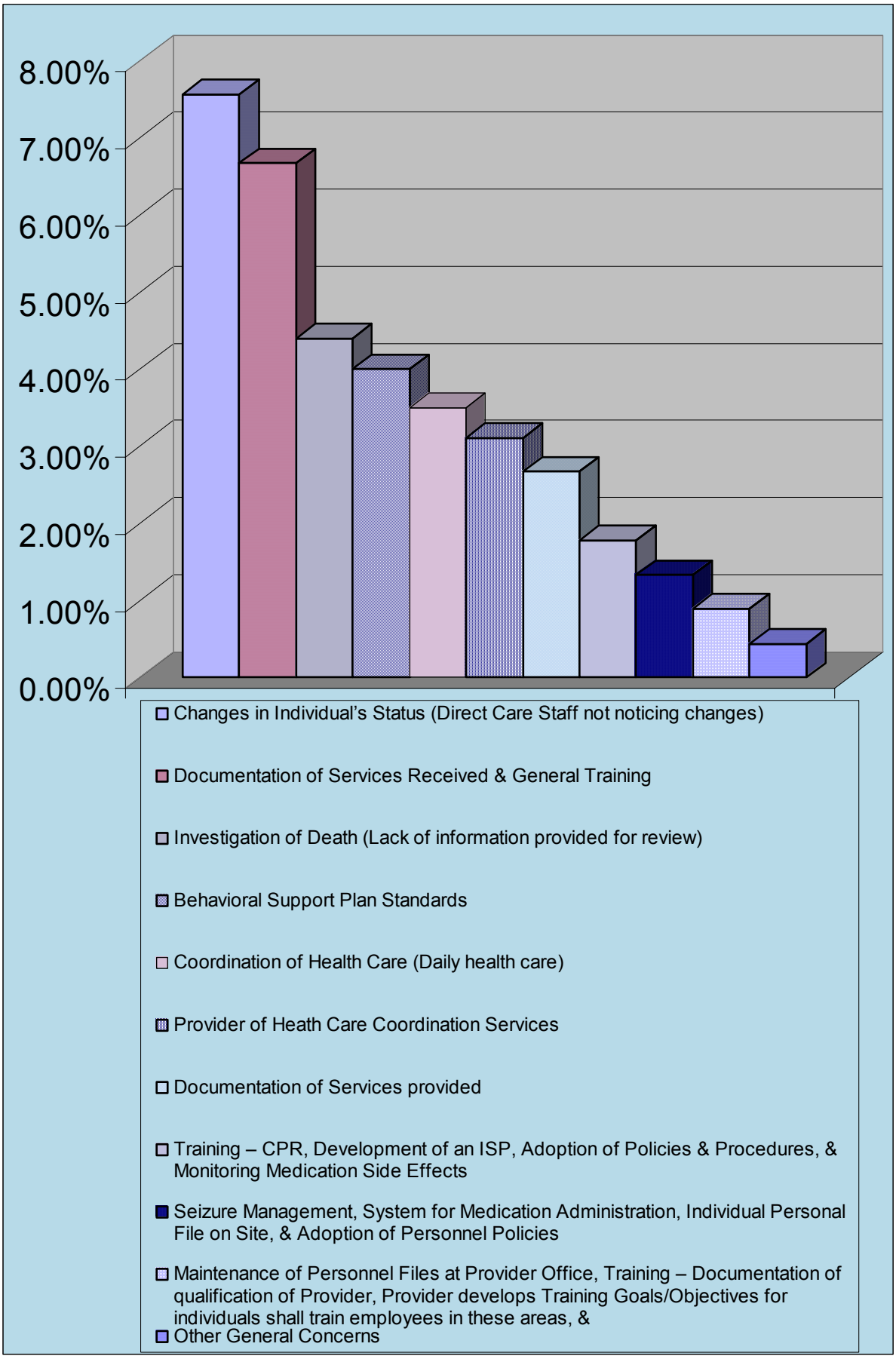
Prior to 2003, the MRC review process focused mainly on those individuals receiving services through the DD Waiver. The MRC's Policy was revised in 2003 to include other programs offered through BDDS (Autism Waiver, State Line item services, etc), as well as deaths of individuals who had developmental disabilities and were receiving services through the A & D Waiver.

Causes of Death by Year

The following is a representation of the Causes of Death reported on a yearly basis.

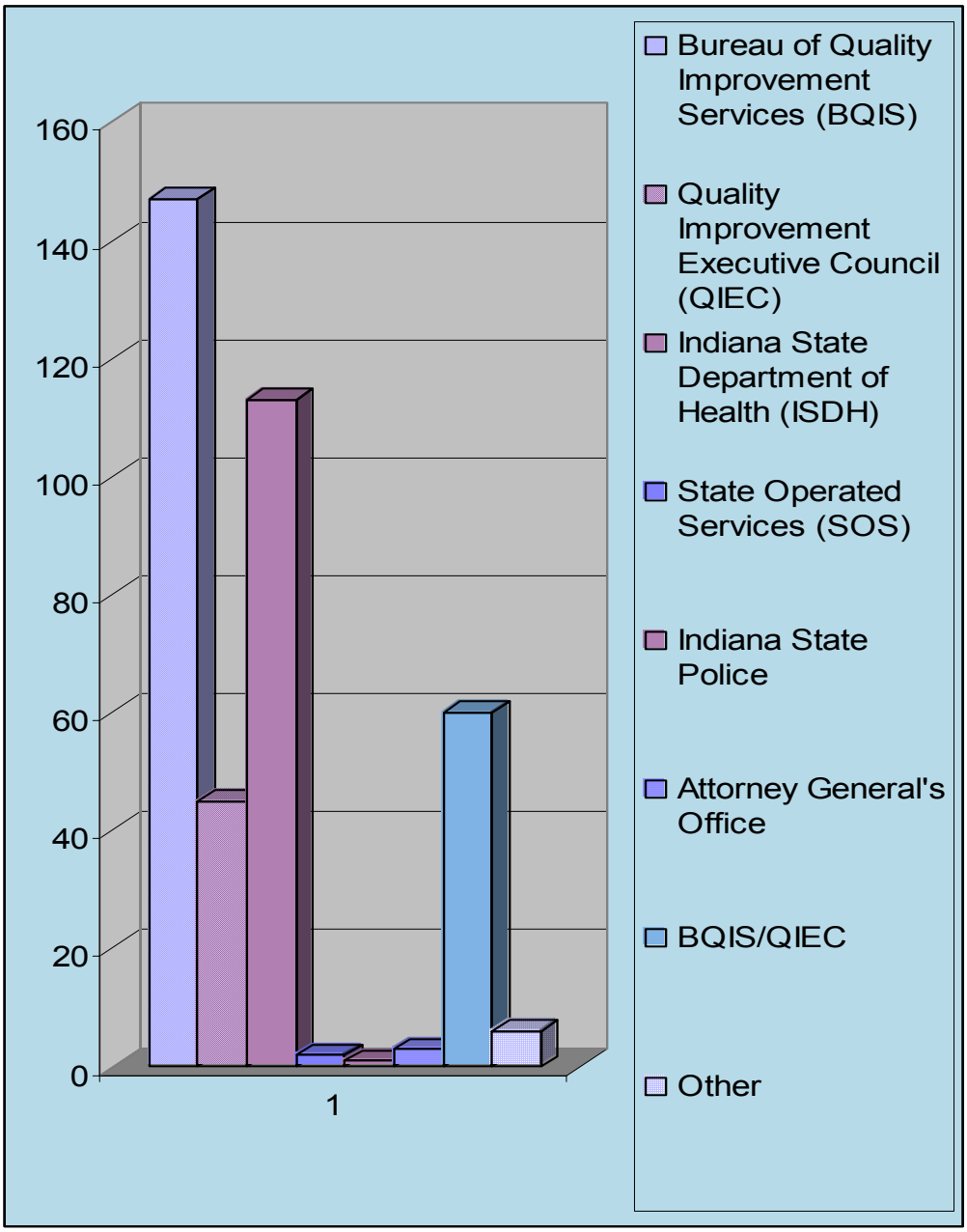


Areas of Concern Noted The following representation depicts the area of concerns identified by the MRC as issues needing to be addressed.


8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Changes in Individual's Status (Direct Care Staff not noticing changes)
Documentation of Services Received & General Training
Investigation of Death (Lack of information provided for review)
Behavioral Support Plan Standards
Coordination of Health Care (Daily health care)
Provider of Heath Care Coordination Services
Documentation of Services provided
Training – CPR, Development of an ISP, Adoption of Policies & Procedures, & Monitoring Medication Side Effects
Seizure Management, System for Medication Administration, Individual Personal File on Site, & Adoption of Personnel Policies
Maintenance of Personnel Files at Provider Office, Training – Documentation of qualification of Provider, Provider develops Training Goals/Objectives for individuals shall train employees in these areas, &
Other General Concerns

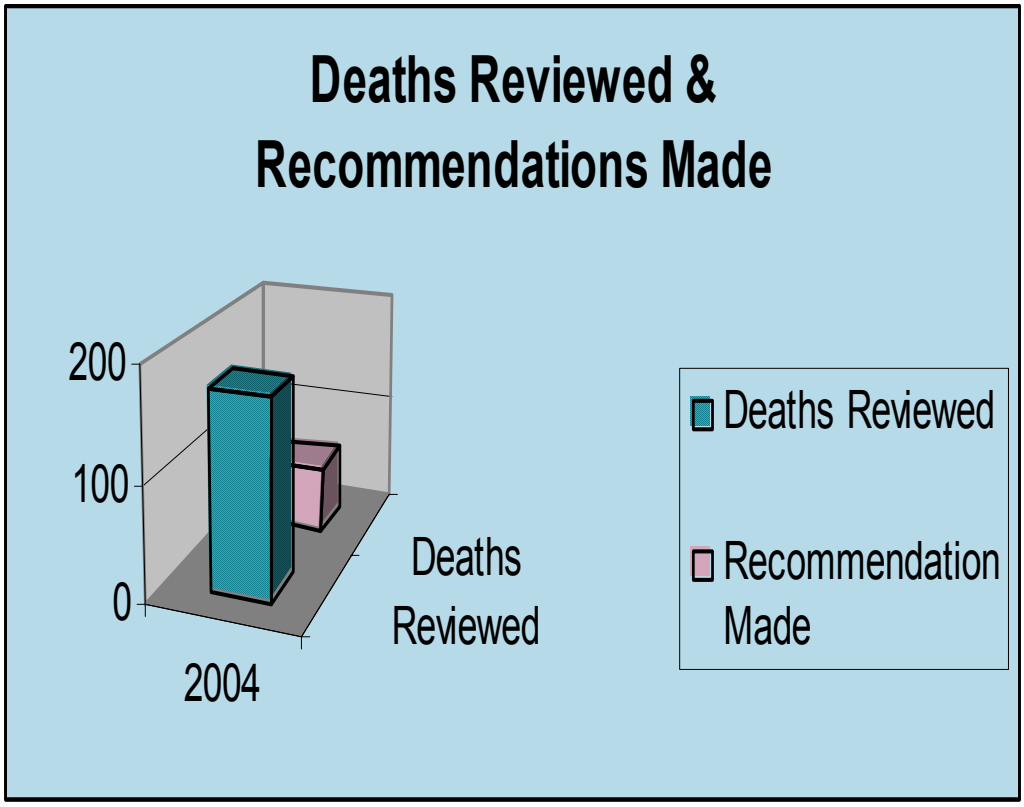
Referrals

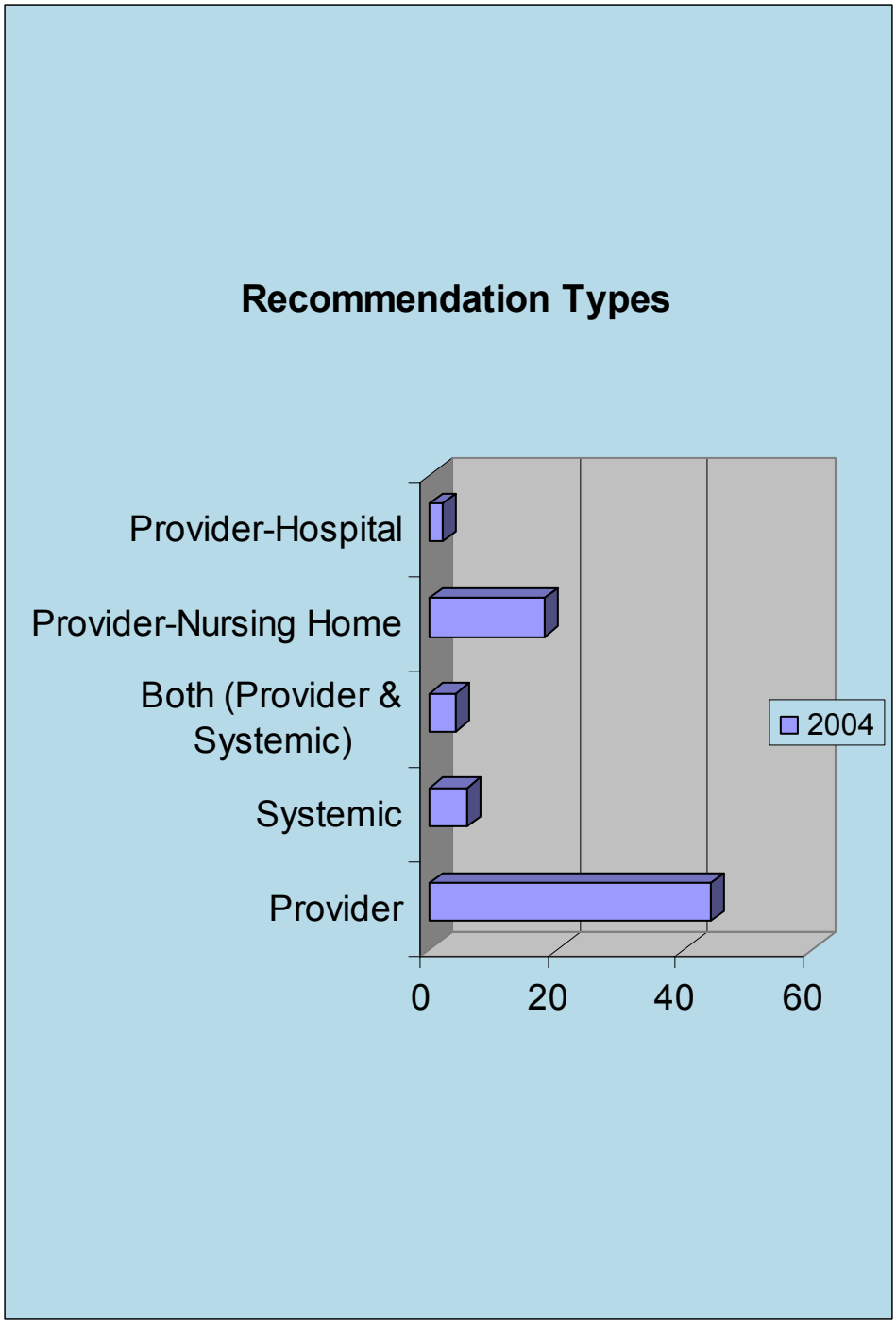
In general, since the Provider Sanctions came into effect, the MRC's Provider Recommendations consist of referrals made to the following agencies.

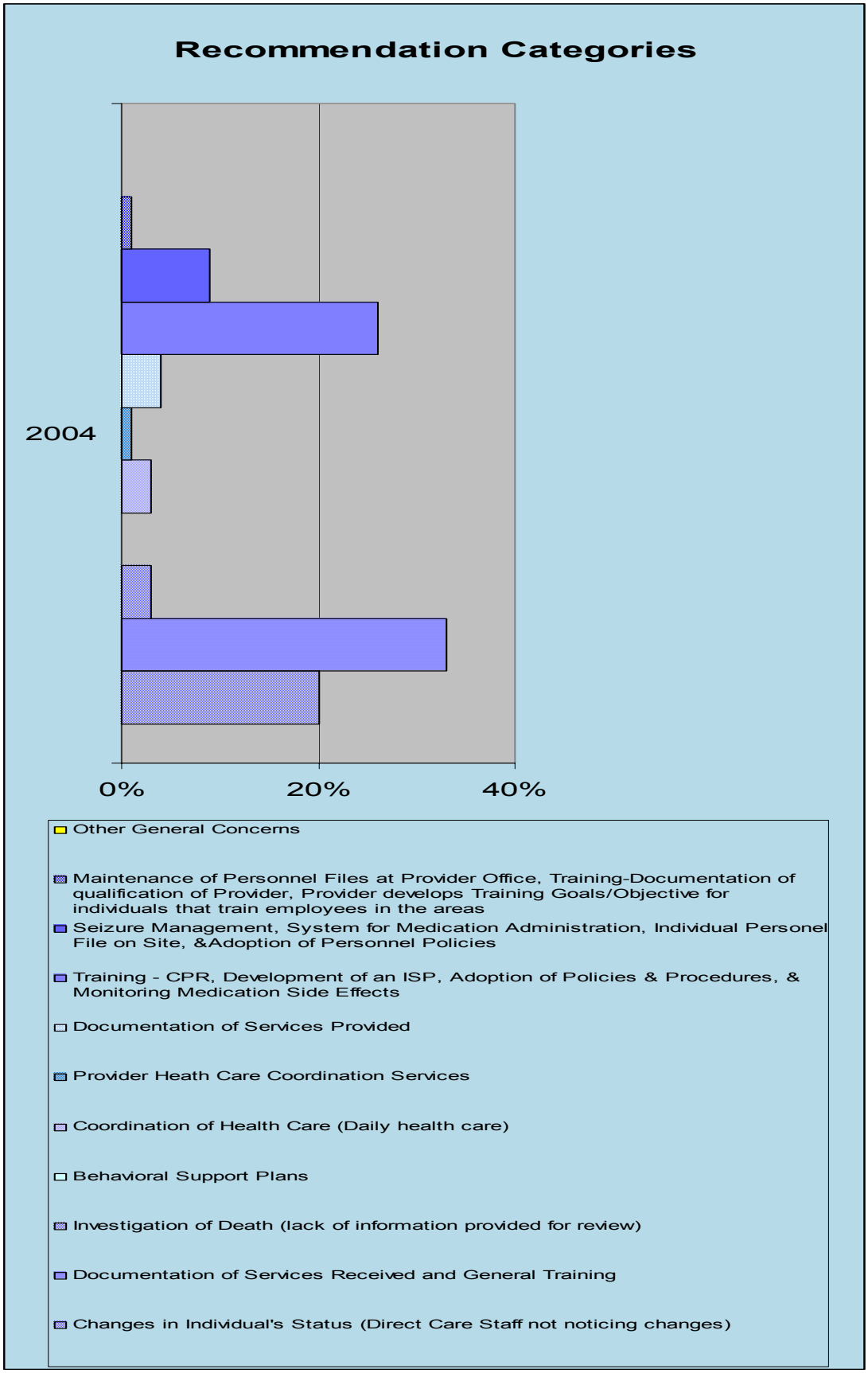


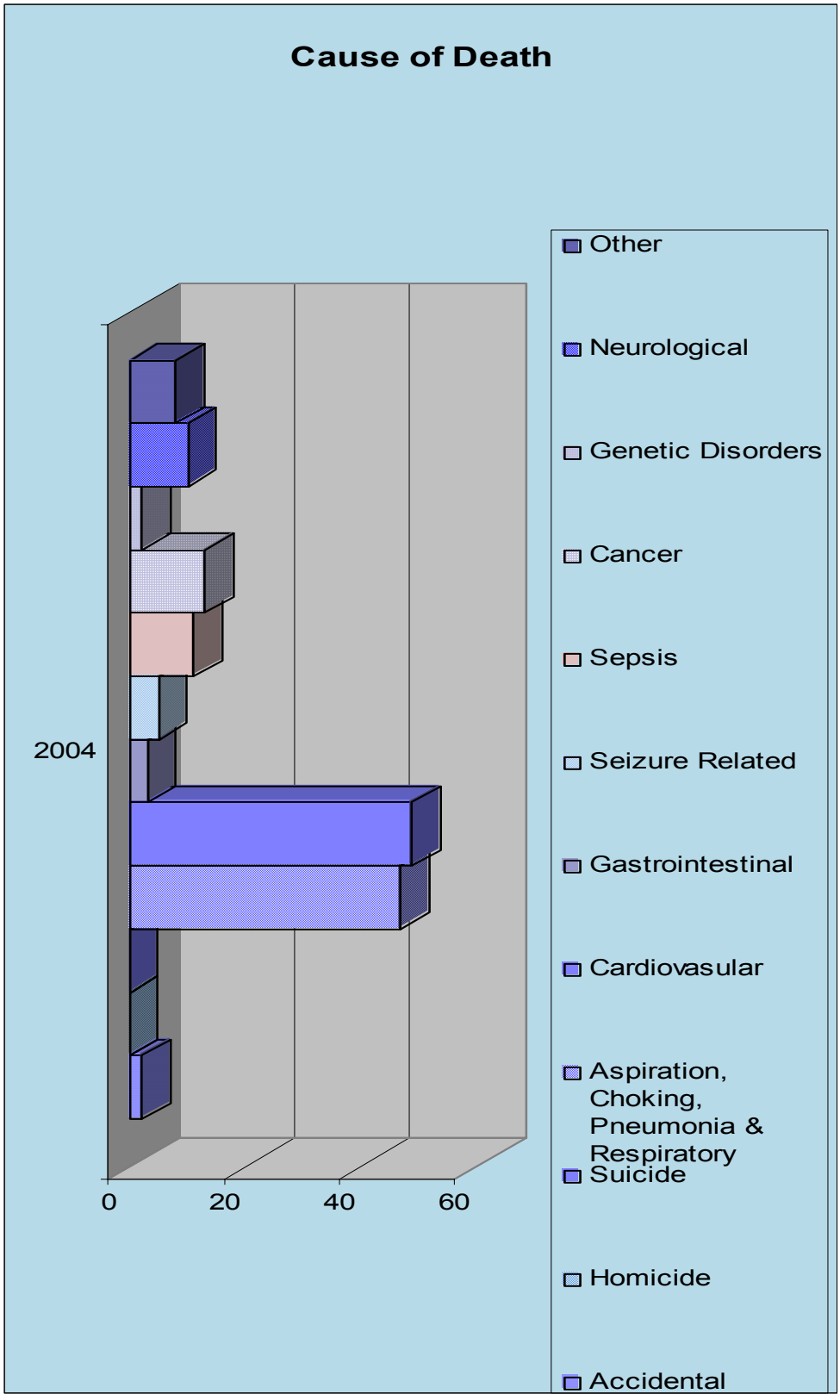
2004 Statistics

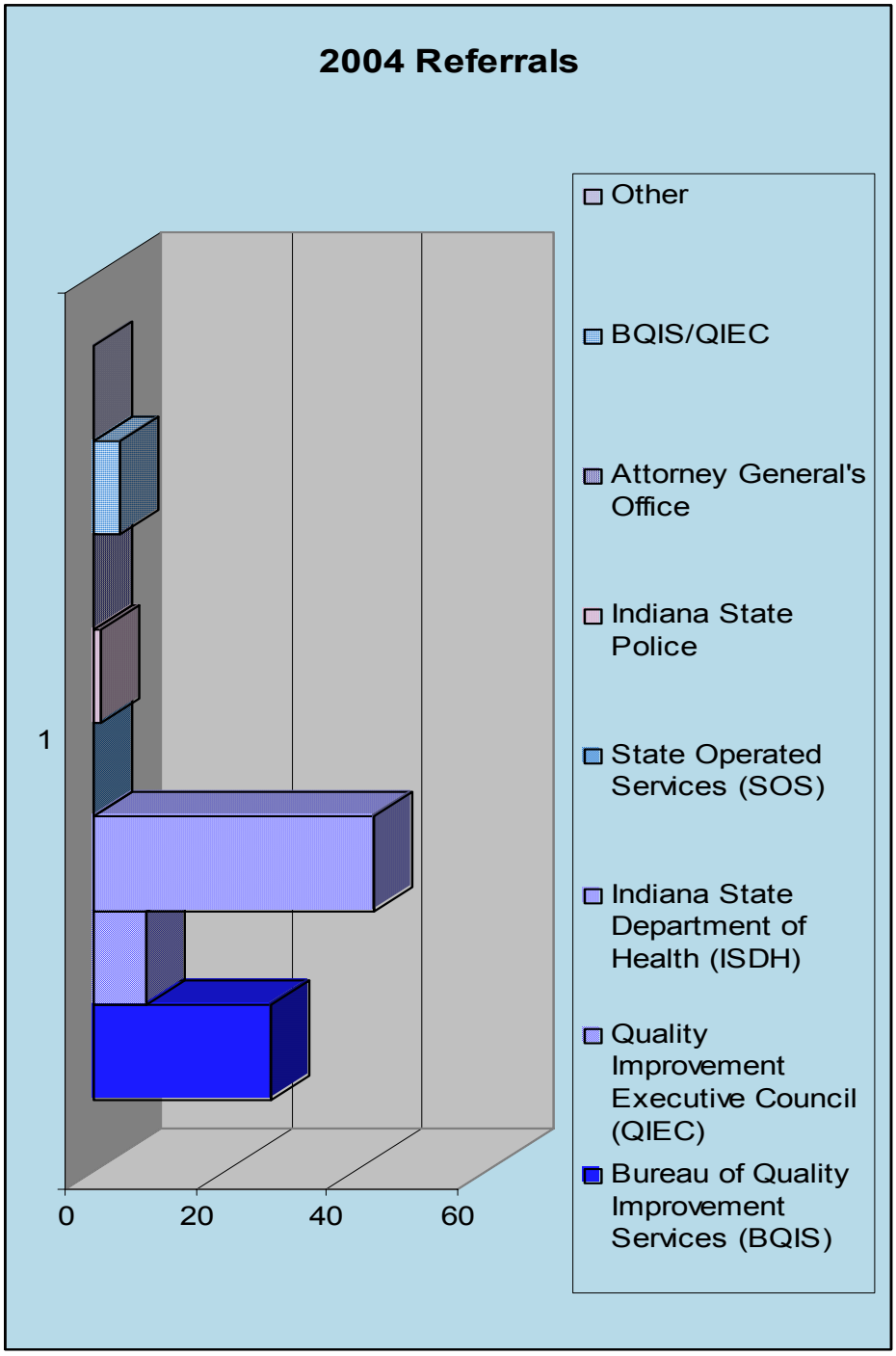
The charts below are representations of the statistics for the calendar year of 2004.

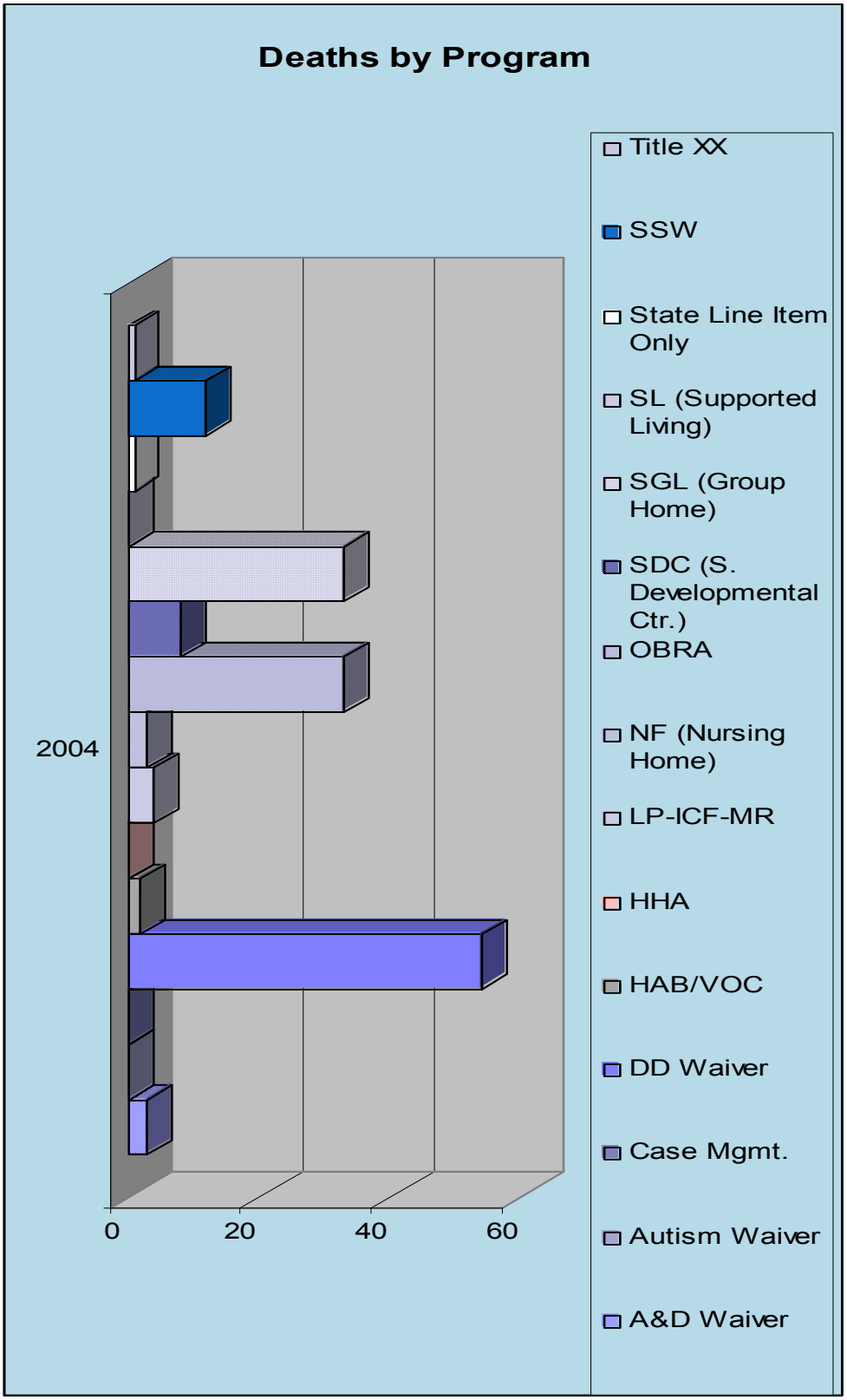



Recommendation Types
Provider-Hospital
Provider-Nursing Home
Both (Provider & Systemic)
Systemic
Provider
0
20
40
60
2004


Recommendation Categories
2004
0%
20%
40%
Other General Concerns
Maintenance of Personnel Files at Provider Office, Training-Documentation of qualification of Provider, Provider develops Training Goals/Objective for individuals that train employees in the areas
Seizure Management, System for Medication Administration, Individual Personel File on Site, &Adoption of Personnel Policies
Training - CPR, Development of an ISP, Adoption of Policies & Procedures, & Monitoring Medication Side Effects
Documentation of Services Provided
Provider Heath Care Coordination Services
Coordination of Health Care (Daily health care)
Behavioral Support Plans
Investigation of Death (lack of information provided for review)
Documentation of Services Received and General Training
Changes in Individual's Status (Direct Care Staff not noticing changes)


Cause of Death
2004
0
20
40
60
Other
Neurological
Genetic Disorders
Cancer
Sepsis
Seizure Related
Gastrointestinal
Cardiovasular
Aspiration, Choking, Pneumonia & Respiratory
Suicide
Homicide
Accidental


2004 Referrals
Other
BQIS/QIEC
Attorney General's Office
Indiana State Police
State Operated Services (SOS)
Indiana State Department of Health (ISDH)
Quality Improvement Executive Council (QIEC)
Bureau of Quality Improvement Services (BQIS)
1
0
20
40
60


Deaths by Program
2004
0
20
40
60
Title XX
SSW
State Line Item Only
SL (Supported Living)
SGL (Group Home)
SDC (S. Developmental Ctr.)
OBRA
NF (Nursing Home)
LP-ICF-MR
HHA
HAB/VOC
DD Waiver
Case Mgmt.
Autism Waiver
A&D Waiver